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FOR ACTION

RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR PROGRAMMES IN THE AFRICA REGION WITH ANNUAL PLANNING LEVELS NOT EXCEEDING $750,000

SUMMARY

The present document contains recommendations for funding from general resources and supplementary funds for programmes with annual planning levels not exceeding $750,000. The Executive Director recommends that the Executive Board approve the following amounts from general resources, subject to the availability of funds, and the following amounts in supplementary funds, subject to the availability of specific-purpose contributions, for the country programmes listed below:

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Equatorial Guinea	2 500 000	4 000 000	1991-1995
Sao Tome and Principe	2 500 000	1 000 000	1991-1995
Swaziland	2 500 000	4 675 000	1991-1995

Summaries of individual recommendations follow.

I. EQUATORIAL GUINEA

U5MR: 214
IMR: 145
GNP per capita: $430

Child population (0-5 years): 59,800
Literacy (male/female): 30 per cent
Access to health services: 55 per cent

One-year-olds fully immunized against:

tuberculosis:	60 per cent
diphtheria/pertussis/tetanus:	40 per cent
measles:	50 per cent
polio:	40 per cent

Pregnant women immunized against:

tetanus:	40 per cent

The situation of children and women

1. Since Equatorial Guinea achieved independence in 1968, it has faced serious economic and social problems. Although the actual rate of growth of the gross domestic product (GDP) is 4 per cent annually, only 9 per cent of the economically active population is formally employed and more than 40 per cent of the population earns less than $180 per year. Over the last decade, the country's external debt has grown from $57 million to $218 million. Yet, despite such economic constraints, social sector allocations for health, education and women's development have increased during the last four years from 7 to 12 per cent of the budget.

2. Despite government and community interventions, the infant mortality rate (IMR) and under-five mortality rate (U5MR) remain high (145 and 214 per 1,000 live births, respectively), caused primarily by diarrhoea, acute respiratory infections (ARI) and measles. Approximately 12 per cent of infants have low birth weight and 8 per cent are premature. The devastating maternal mortality rate (MMR) of 400 per 100,000 live births may even be higher since it does not take into account widespread underregistration. Only 25 per cent of pregnant women receive institutional care during childbirth.

3. Approximately 47 per cent of school-age children still do not attend primary school despite recent efforts to encourage enrolment. School repetition and drop-out rates are very high, primarily because Spanish, the official language used in schools, is not widely known. Pre-school education is practically non-existent.

4. About 70 per cent of the population lack access to safe drinking water and only 4 per cent have piped water in their homes. Because of difficulties associated with the subsistence economy and the country's culture and traditions, women's working conditions in agricultural production and

marketing and at home are frequently harsh. Girls often become mothers while they are still very young themselves (14 to 15 years of age), which prevents them from completing school and puts them at further high risk.

Programme co-operation, 1987-1990

5. The programme of co-operation covering the period 1987-1990 had two stages. During the first stage (1987-1988), the principal activities supported the provision of supplies for several primary health care (PHC) components (expanded programme on immunization (EPI), control of diarrhoeal diseases (CDD) and malaria); equipped health centres; supplied school gardens; and provided primary education materials, equipment for food preparation and transportation. The most serious constraints during this period were weaknesses in certain aspects of programming. Objectives to reduce morbidity and mortality, for instance, were too broad. Moreover, the absence of an annual programming exercise meant that the number of mothers and children benefiting from the programme was not identified, nor was the impact assessed.

6. In the second stage (1989-1990), UNICEF response to programme requirements improved, as did programming, management and follow-up capacity in PHC, with an emphasis on immunization and oral rehydration therapy (ORT); in non-formal, pre-school education; and in supporting improved nutrition and food production among women. Increased immunization coverage put the country within reach of achieving universal child immunization (UCI) by 1990. Morbidity from measles was drastically reduced from 15,000 cases in 1988 to fewer than 600 in 1989, with no cases of measles reported in 1990. The number of severe dehydration cases has fallen as a result of the ORT programme. Community participation in PHC activities and in developing programmes for pre-school children in rural areas has grown. Support was also given to women's groups for income-generating activities in agricultural production and marketing.

7. Thus, experience proves that cooperation makes it possible to reach goals, enhance the efficiency of government departments, greatly increase community participation through the involvement of traditional community structures and generate social mobilization activities relevant to the established objectives.

Recommended programme cooperation, 1991-1995

	General resources	Supplementary funds	Total
	(thousands of United States dollars)		
Health	1 000	2 500	3 500
Non-formal education	450	180	630
Women	420	-	420
Water and sanitation	250	1 320	1 570
Programme support	380	-	380
Total	2 500	4 000	6 500

8. Based on the situation analysis of women and children, the objectives established for the period 1991-1995 are to reduce IMR from 145 to 115 per 1,000 live births; reduce U5MR from 214 to 150 per 1,000 live births; reduce MMR from 400 to 300 per 100,000 live births; serve the development needs of 6,000 children from three to six years of age; contribute to improving the nutritional status of families and support food production and marketing activities of 10,000 women on the mainland, who are organized into 200 women's groups; and improve the provision of safe drinking water in 250 rural communities to benefit approximately 88,000 people.

9. These objectives are considered feasible based on the social development strategy of providing basic services to improve the well-being of women and children through the promotion of community participation. Support will be provided to strengthen community organization and participation in programme implementation, self-management, monitoring and evaluation; to develop communication and social mobilization activities to promote, train and mobilize the beneficiaries of the programme; to promote intra- and inter-sectoral coordination; to coordinate the activities of cooperating agencies to optimize integration of efforts and avoid duplication of services and loss of resources; and to promote the use of easily adopted, simple technologies.

10. The Government seeks to strengthen PHC; non-formal, pre-school education; support to food production and marketing activities carried out by women and to efforts to improve nutrition; and the provision of safe drinking water and environmental sanitation in rural areas. These actions, together with other activities being carried out as part of the country's social development policy, will help to ensure that the objectives outlined above are achieved.

Primary health care

11. The PHC programme is a priority of the Ministry of Health, with all levels of the system involved in its development. Support will be provided for health promotion, preventive care, treatment and rehabilitation services. Programme components such as immunization, CDD, treatment of ARI and health education are integral parts of the services to be offered to the community, mainly through health centres and PHC committees, as well as through second-level referral health centres and eight hospitals. The community participates in all stages of PHC services, including self-management and financial support under the umbrella of the Bamako Initiative. Children under five years of age and mothers are the primary beneficiaries.

12. One programme objective is to strengthen policies ensuring the availability, accessibility and rational and responsible use of essential drugs by the population. The programme will also support community participation and the development of self-management systems and assist the community in financing the PHC programme in the spirit of the Bamako Initiative through rotating funds for the routine replenishment of essential drugs. The strategy is to initiate activities in selected districts with the greatest potential for the development of PHC and to expand activities

progressively to all districts. Administrative decentralization measures of the Ministry of Health will be applied while communities gain experience in managing rotating funds and in self-management of PHC.

13. Expanded programme on immunization. The project aims to maintain immunization coverage at 80 per cent for each antigen for children under one year of age (13,800) and 95 per cent coverage of pregnant women with two doses of tetanus toxoid (17,300). It also aims to eradicate poliomyelitis and neonatal tetanus by 1995. The objectives will be achieved through carefully planned accelerated immunization in the communities served by the 31 fixed centres, through house-to-house channelling every weekend in the three principal cities (Malabo, Bata and Ebinayong).

14. Control of diarrhoeal diseases. The objectives of the project are to reduce mortality due to diarrhoeal dehydration in children under five years of age by 50 per cent by 1995 and to reduce morbidity by decreasing the number of diarrhoeal episodes each year from four to two in children under one year of age and from eight to seven in children under five years old. Specific strategies to achieve those objectives include the promotion at the community level of the early use of ORT in children at risk of dehydration; the promotion of hygienic practices and the appropriate use of water and sanitation; and referral of children with severe dehydration to health centres or oral rehydration units, of which an additional 21 units will be established.

15. Acute respiratory infections. The project aims to reduce mortality in children one to four years old from ARI by 40 per cent by 1995. Specific strategies include the systematic detection and treatment of ARI at first-level health centres and by PHC committees; assuring the appropriate referral and treatment of the most acute cases to the second and third referral levels; and improving the knowledge of mothers and the community about preventive measures and treatment that can be initiated immediately.

16. Malaria control. The objective is to reduce mortality from malaria in pregnant women and in children under five years of age, specifically through the use of chemoprophylaxis for pregnant women from their first prenatal visit and the diagnosis and treatment of malaria symptoms in children. Activities will be carried out by PHC personnel at prenatal clinics in health centres, in health posts and through house-to-house visits.

17. Maternal health services. Maternal morbidity and mortality related to pregnancy and delivery is to be reduced by 25 per cent by 1995 through interventions including the training of traditional birth attendants (TBAs) and their incorporation into PHC committees. Essential drugs will be made available at second- and third-level health centres for high-risk mothers, and community-based health education will be provided to prevent high-risk pregnancies.

Basic education

18. This programme will serve to improve the quality of primary education, facilitate the timely admission of children (seven to eight years of age) and reduce repetition and drop-out rates. Responding to the development needs of children from three to six years of age in rural and peri-urban areas, the goal is to serve 6,000 pre-school-age children in 150 communities by 1995 (at present 800 children in 20 communities are being served). The programme is based on a national curriculum that has objectives in the four areas of intellectual, communication skills, psycho-motor and psycho-affective development. Children are taught for five hours per day by education promoters, community members who are selected by the community and trained. Children receive daily snacks prepared by groups of mothers using food provided by the community and the national nutrition programme. The community also provides the daily workspace, furnishings and maintenance.

Household food security

19. Because each family's survival relies on women's labour, support will be given to agricultural production, diversification and marketing activities carried out by women in rural areas. Through organization, training, technical assistance and revolving credit, production activities are expected to become more profitable, increasing women's incomes and contributing to improved family nutrition. The goal is to assist 10,000 women grouped into 200 organizations in six districts on the mainland by 1995. At present, there are approximately 60 women's groups in this area.

Water supply and sanitation

20. This programme aims to improve sanitation for approximately 88,000 people in 250 rural communities by providing potable water to 35 per cent of the rural population on the mainland and 45 per cent in the island region by 1995. The training of 50 sanitation workers is a fundamental part of the work being carried out. The organization and development of sanitation facilities will include the protection of water sources and the installation of wells and facilities such as latrines.

Communication and social mobilization

21. Communication and social mobilization activities are an integral part of the programming process. The objective is to ensure the involvement of the six target audiences: beneficiaries; community organization leaders; ministry and institutio personnel; members of non-governmental organizations (NGOs) and cooperating agencies; political leaders and civil servants; and the media. The specific strategies utilized have included the precise identification of the concerns of audiences and the development of messages appropriate to each target audience, transmitted via appropriate channels.

Cooperation with United Nations agencies and other partners

22. The programme process involved continuous discussions with United Nations and bilateral agencies, which were effective in ensuring complementarity and avoiding duplication. Cooperation with national and international NGOs will be strengthened.

II. SAO TOME AND PRINCIPE

U5MR: 136
IMR: 69
GNP per capita: $272

Child population (0-5 years): 22,000
Literacy (male/female): 59/53 per cent
Access to health services: 100 per cent

One-year-olds fully immunized against:

tuberculosis:	89 per cent
diphtheria/pertussis/tetanus:	64 per cent
measles:	46 per cent
polio:	69 per cent

Pregnant women immunized against:

tetanus:	38 per cent

The situation of children and women

23. The two islands of Sao Tome and Principe, which lie south of Nigeria and west of Gabon, form one of the smallest and most isolated States in the world. Independent since 1975, the country is struggling to strengthen and diversify the precarious monoculture economy bequeathed by the Portuguese based on cocoa, an agricultural product that no longer commands high prices on the world market.

24. Despite the islands' poverty, health services are considered relatively good by sub-Saharan standards: 86 per cent of births are assisted by trained health personnel and 68 per cent take place in maternity units. Only 5 per cent of newborns weigh less than 2.5 kilograms and 87 per cent of children are breastfed for 12 months or more. Yet problems persist. In 1986, 16.6 per cent of children under five years old suffered from moderate or severe malnutrition based on weight for age, and 5 per cent suffered from moderate or severe malnutrition based on height for age.

25. The fertility rate is 7.18 children per woman (1987). Access to contraception is potentially universal, although utilization is reported at only 10 per cent, largely owing to a lack of information and strong traditional sociocultural factors. MMR is 80 per 100,000 live births.

26. Only 21 per cent of households have access to safe drinking water, 9 per cent to sewers and 11 per cent to latrines. The incidence of diarrhoeal diseases remains high, and in 1989, a serious outbreak of cholera affected some 2,000 persons, with 70 deaths being registered. Breeding grounds for malaria and intestinal parasites proliferate, a result of environmental deterioration.

27. The main causes of infant mortality are malaria, diarrhoea and ARI, and measles is still a threat. Drugs are, in principle, free of charge, but they are scarce and distribution is irregular owing to the inadequately funded

centralized system. Community health workers (CHWs), provided with proper training, supervision and regular supplies, could strengthen basic health care and education support at the community level, but the current 161 CHWs have not yet been integrated into the health network.

28. Although around 90 per cent of children are registered in primary schools, acute shortages of classrooms, teachers and equipment mean that many attend school only for two to three hours a day. The repetition rate (28 per cent) is high. The adult literacy rate is 56 per cent and there is no ongoing literacy programme. Pre-schools, a tradition in Sao Tome and Principe, numbered 173 in 1990. However, existing pre-schools meet only 30 per cent of the need, particularly for children between the ages of three and six years old. The percentage of the national budget allocated to education has decreased over the last decade, from a high of 10 per cent to 5 per cent in 1989.

Programme cooperation, 1986-1990

29. The previous programme of cooperation, 1986-1990, was suspended in 1987 and resumed in 1988, with a bridging programme for 1989-1990.

30. The key features of UNICEF assistance were to support accelerated EPI through the provision of vaccines, vaccination and cold-chain equipment, transport, training of CHWs and social mobilization activities; the strengthening of nutrition rehabilitation and growth monitoring services; the promotion of ORT by ensuring the supply of oral rehydration salts (ORS); the provision of essential drugs to seven district maternal and child health (MCH) centres, 27 vaccination posts and 7 maternity wards. Some 60 members of the national women's organization were also trained in child nutrition, ORT and basic child care, and pre-school equipment was provided.

31. While programme achievements have been considerable, there is no doubt that the 18 months' suspension had repercussions. Although a target for 1988, UCI has not yet been attained owing to shortages of vaccines, equipment and human resources. The lack of reliable statistics (the last census was in 1981) has also affected planning assessment.

32. Pending the formulation of an overall plan for the future functions of the National Centre for Health Education, support has been delayed. The shortage of human resources for planning and implementation has not allowed a real start of the water supply and sanitation project. In addition, area-based programmes for disadvantaged districts of Caué, Lemba and Pagué remain without funding.

Lessons learned

33. In view of national budget limitations that can be solved only in the long term and the need to sustain and improve the quality of social services, future programmes must stress the involvement of communities themselves in planning and financing projects, with an emphasis on improving access to health and education services for the largest number of people possible.

34. There is also a need for concerted inter-agency (United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), World Food Programme (WFP), World Health Organization (WHO) and World Bank) support and action to derive maximum benefit from limited resources, while minimizing the impact of the structural adjustment programme (SAP).

Recommended programme cooperation, 1991-1995

	General resources	Supplementary funds	Total
	(thousands of United States dollars)		
Health	750	250	1 000
Non-formal education	250	250	500
Area-based integrated development	300	500	800
Programme support	1 200	-	1 200
Total	2 500	1 000	3 500

35. Based on an analysis of the situation of children and women in Sao Tome and Principe, the new country programme has been developed in collaboration with members of the Steering Committee and UNICEF, national and international consultants and inter-agency consultation.

Health

36. The overall goal is to reduce IMR from 70 to 55 per 1,000 live births by 1995. To reach this goal, two strategies are needed: one is to support existing MCH services through supplying vaccines, immunization equipment, growth charts, ORS and building the capacity of health agents at all levels, and the second is to contribute to a decentralized health system that involves the community, thus improving access to MCH and basic health services through a Bamako Initiative approach. With the World Bank providing 80 per cent of all essential drugs, UNICEF will ensure their efficient and regular distribution and organize management training, especially at the district level.

Non-formal education

37. To find alternative solutions to the problem of providing pre-school service, 23 low-cost child centres, run by the community, will be created. Caretakers chosen by communities themselves will receive training and supervision. Toys and pedagogical items will be made locally. WFP will provide food assistance and support is expected from youth's and women's organizations.

38. Inspired by the recommendations of the World Conference on Education for All held in Jomtien, Thailand, in 1990, 45 groups of at least 30 primary-school-age children, largely from poor areas, have been formed. The children will participate in non-formal education activities organized outside school hours that aim to impart essential "skills for life" to complement regular studies. Parents, teachers, mass organizations and churches will be partners in the effort.

Area-based integrated development

39. In the isolated and disadvantaged district of Paguí and the peri-urban area of the capital, UNICEF will contribute to existing women's development projects with integrated components of water supply and sanitation, health, household food security and alternative pre-schools. Empowering the community to identify and solve its problems, as well as to monitor and manage its own basic health and social services, will be a special priority.

Programme support

40. Programme support will cover the salary for a Liaison Officer and supporting staff and office expenses. A Junior Professional Officer will also be hired for a two-year period. Monitoring and evaluation will be conducted regularly on a monthly, quarterly or annual basis according to specific programme indicators. A mid-term review of cooperation will be held in 1993. The UNICEF/Government Steering Committee and the area office in Luanda will play an important role in technical assistance, supervision and follow-up.

Cooperation with the United Nations and other organizations

41. Particularly close cooperation exists with UNDP, WFP, WHO, the United Nations Development Fund for Women (UNIFEM) and UNFPA. Programme components and project sites have been chosen to complement, where possible, ongoing activities of other agencies. Links with NGOs, such as the Associaóáo dos Amigos da Crianóa, will be strengthened.

III. SWAZILAND

U5MR: 140	Child population (0-5 years): 150,000
IMR: 100	Literacy (male/female): 69/65 per cent
GNP per capita: $759	Access to health services: 80 per cent

One-year-olds fully immunized against:

tuberculosis:	96 per cent
diphtheria/pertussis/tetanus:	89 per cent
measles:	85 per cent
polio:	89 per cent

Pregnant women immunized against:

tetanus:	63 per cent

The situation of children and women

42. Swaziland's IMR is higher than might be expected for a small, middle-income country where access to health services is relatively easy. Around 50 per cent of all infant deaths occur before the age of two months and 70 per cent of all under-five deaths occur before six months of age. Hospital-based data point to four major causes of infant mortality: perinatal conditions (29 per cent); diarrhoea (23 per cent); ARI (15 per cent); and malnutrition (11 per cent). Some 50 per cent of perinatal deaths are associated with low birth weight. An additional one third of all infant deaths are attributed to diarrhoea or malnutrition, each disease associated with and compounding the other. Low birth weight would not exact its present toll if there were better identification of mothers at risk, improved referral and better care of low birth-weight babies in hospitals and homes. Diarrhoea and associated malnutrition could be reduced dramatically if mothers breastfed their babies exclusively for at least four to six months. The average age at which non-breast milk is currently introduced is one to two months. ARI would not add significantly to IMR if there were better home treatment of mild cases and more prompt referral of severe ones. At present the "too little, too late" syndrome comes into play and increases the risk of death from all causes. Traditional healing is a powerful parallel system that can improve health and contribute to reducing infant mortality. The Government has recognized the need to train traditional healers in PHC, and began the training project in 1990.

43. Thirty per cent of all Swazi children do not achieve the full growth potential of their first three years of life. Stunting is more likely to occur among children whose families have the least resources, especially those with limited or no access to cash from wage earnings, remittances (mostly from family members working in South Africa) and informal sector activities. Because few homesteads are self-sufficient in maize, food shortfalls due to underproduction have to be offset by food purchases at high prices. Household

food security, therefore, becomes dependent on adequate income sources. Income distribution, however, is severly skewed, and 81 per cent of the rural population falls below the poverty line. Vulnerable households without access to wages or remittances constitute 27 per cent of all households and they are mostly headed by women. The picture of a woman-headed household is one of underendowment, with a less-than-average area of land, upon which less labour and money are spent, resulting in smaller food and cash crops and diminished food security. The woman-headed household emerges as the "poorest of the poor".

44. The enrolment rate in primary school is impressive (76 per cent), but parents often cannot afford to pay school fees and attrition rates are high. Fifty per cent of children drop out by grade seven, especially girls who become pregnant. Repetition of grades is common. On average, it takes a child 12 years to complete seven grades of primary education. Estimates of the percentage of children 6 to 13 years old not in school range from 10 to 20 per cent. Some 37 per cent of the adult population remain illiterate. Marginalized groups, such as street children, are drop-outs from the education system.

Programme cooperation, 1984-1990

45. In the last seven years, the programme has focused on strengthening MCH services, and projects such as improved young child feeding and women in development.

Maternal and child health

46. Swaziland achieved UCI in 1990 (83 per cent complete coverage). The strong points of the immunization programme are the dedication of staff, the quality of educational materials and the capability to monitor disease outbreaks. The main weakness was in programme management and supervision, resulting in a lack of control of programme performance at regional and peripheral levels. Financial sustainability will be an issue in the near future.

47. In 1985, a mass media ORT campaign promoting salt-sugar solutions (SSS) was successful in raising the percentage of mothers knowing the correct SSS formula to 60 per cent. There was a 22 per cent decline in the number of diarrhoea outpatient cases (children under-five years old) over the 1983-1986 period and a 50 per cent decline in under-five mortality due to diarrhoea over the 1981-1986 period. Over the last three years, further gains have been made through redeployment of staff, training and the opening of ORT units throughout the country. Although ARI was twinned with CDD, its progress has not kept pace with that of the latter.

48. UNICEF has helped to strengthen Ministry of Health services and nutrition education, with special emphasis on exclusive breast-feeding. Growth monitoring coverage of infants under one year old increased from 25 per cent in 1983 to 40 per cent by 1987, while that of children between 12 to 23 months

increased from 28 to 50 per cent in the same period. Between 1984 and 1990, UNICEF helped to train 1,600 rural health motivators, rural women who volunteer their services and advice at homestead level to approximately 50 per cent of the population. They have been the main government mobilizers for child survival, protection and development. Indicators of success have been a reduction in the attrition of rural health motivators, increased community awareness and involvement, increases in the number of rural health motivators selected every year by the chiefs for training and high levels of community knowledge, especially with regard to immunization and ORT.

Improved young child feeding

49. Social marketing techniques were used in this project to develop a communications programme for the promotion of breast-feeding and sound weaning practices. The research and material-production phases are completed and training is under way. Training will continue during the new programming cycle and lead, in turn, to the monitoring of impact. The project provides an example of excellent inter-agency cooperation between the United States Agency for International Development (USAID) and UNICEF, and has forged linkages between various ministries and NGOs. Efficiency has been improved through a systematic approach to advocacy, information delivery and social mobilization. However, the project has not had much success in motivating mothers to breast-feed exclusively for longer durations.

Women in development

50. Since 1976, UNICEF has contributed to the UNDP women in development project to promote the capacity of rural women to earn supplementary incomes. Between 1984 and 1990, 900 women have received training in block-making, tile-making, construction techniques, water and grain storage construction, welding, sewing and handicrafts. The programme has gained considerable momentum over the last two years, with improvements in the targeting of poor women. On average, 400 women every year have benefited from literacy skills associated with child survival messages.

51. Over the years, the weaknesses and strengths of the programming context have become apparent. There are staff shortages at all levels of Government and a brain-drain to South Africa. Because of the high staff turnover, there is a need for continual orientation and advocacy. Everyday operational problems leave limited time for planning and programming, and some programmes suffer from weak management. Despite constraints, UCI was achieved. There is now evidence of political will at the highest levels of Government, which is committed to the child survival goals of the Organization of African Unity (OAU), the Convention on the Rights of the Child, the Declaration on Education for All and the Declaration and Plan of Action of the World Summit for Children. The Government actively supports NGO efforts and has encouraged UNICEF to develop a wide spectrum of alliances outside the Government.

52. Capability and dedication on the part of service providers have also improved over the years, but technical support and supervision remain weak. Social mobilization has considerably improved community awareness,

organization and responsibility, and the process of decentralizing management has made structures more responsive to community demand. Yet financial sustainability is problematic, with limited cost recovery and community financing of health services. Recurrent expenditure budgets are high, matched by elevated levels of donor funding.

Recommended programme cooperation, 1991-1995

	General resources	Supplementary funds	Total
	(Thousands of United States dollars)		
Maternal and child health	1 300	2 250	3 550
Household food and income security	0	2 425	2 425
Basic education	750	0	750
Programme support	450	0	450
Total	2 500	4 675 a/	7 175

a/ In addition, $550 is already funded from previous programme cooperation.

53. The goal of the country programme is to reduce the high infant, child and maternal mortality within the context of PHC. A major objective will be the reduction of stunting in children under five years old to 15 per cent. The programme seeks to improve the quality and relevance of education given to the young child and adolescent, and to increase access of women and marginalized youth to knowledge, values and life skills required to become better parents and citizens through non-formal education. It confines itself to key strategic interventions that fall within broad national policies and programmes.

54. Four basic strategies will be used to achieve the goals: advocacy; social mobilization; capacity-building; and disparity reduction. Advocacy will be central to the achievement of sectoral goals. A major part of the thrust will focus on greater financial responsibility being assumed by the Government in the strengthening of its services, which would ensure programme sustainability as demonstrated by increased government allocations to social services. Social mobilization, rooted in Facts for Life, will serve as the basis for communicating knowledge and awareness, and in bringing about participation and behavioural changes. Capacity-building will take place at both the national and the community levels. Disparity reduction is more challenging since its root causes lie deep within socio-economic structures. The programme of cooperation sets its sights on the poorest of the poor, targeting women-headed households identified by community leaders and rural health motivators and focuses on three main programme components.

Integrated maternal and child health care

55. This programme consists of five mutually supportive components: EPI; CDD/ARI; safe motherhood; growth monitoring; and rural health motivators. The objective of EPI is to reduce morbidity and mortality from the six target diseases by maintaining UCI coverage levels above 83 per cent. The CDD/ARI project aims at reducing infant and young child mortality and morbidity attributable to diarrhoea and respiratory infections through community education, early recognition, effective home management and timely referral. Linkages with immunization, breast-feeding, weaning, ORT and hand-washing will be strengthened. The safe motherhood component aims to reduce MMR by improving antenatal and postnatal care, counteracting harmful traditional practices, reducing the possibility of complications caused by sexually transmitted diseases, including infection with the human immunodeficiency virus (HIV), and promoting family spacing. Tetanus toxoid immunizations will be provided for all women of child-bearing age. The objective of the growth monitoring project is to reduce the prevalence of chronic malnutrition by increasing the proportions of children attending growth monitoring sessions and of mothers who understand the growth chart. The rural health motivators link all the MCH components by providing basic health and nutrition information across the spectrum of child survival, protection and development. The health sector programme follows the overall lines of the Bamako Initiative strategy for strengthening MCH/PHC, with specific activities to help communities to assume financial responsibility for PHC now under way on a small scale.

Household food and income security

56. The programme consists of three interrelated components: improved young child feeding; income-generating activities for women; and capacity-building. The improved young child feeding component aims to reduce stunting in children under three years old from 30 to 15 per cent by promoting breast-feeding and sound weaning practices, working through the Ministries of Health and Agriculture and the Swaziland Infant Nutrition Action Network. The income-generating project targets female-headed households with little or no access to employment and, therefore, with diminished food security. The programme includes an area-based project that weaves together various interventions within three defined geographical locations, allowing for close monitoring. The capacity-building dimension will develop the ability within the Government, and at community level, to assess, analyse and take action to ensure food security for the most vulnerable.

Basic education

57. The objective of the pre-school component is to promote and support Government and NGO actions designed to integrate care and education of the young child into the basic education cycle. The objective of the Sebenta project is to reduce adult illiteracy from 30 to 15 per cent by 1995. Learning units will be based on Facts for Life. The two main objectives of the curriculum development project are to design a development studies curriculum

for adolescent girls and boys that develops understanding, skills, and values associated with Facts for Life; and to present curriculum material in terms of expected levels of learning and measurable attainment. With the children in difficult circumstances component, the objective is to fulfil the commitment to "Education for All" as it affects underserved street children and out-of-school marginalized youth.

Monitoring and evaluation

58. Within each programme area, the master plan of operations incorporates feedback mechanisms at national and community levels for monitoring progress towards the national programme goals set for the 1990s and the need for timely, corrective actions in the course of annual implementation. Monitoring will be effected through annual reviews, a mid-term review, strengthened departmental monitoring and monthly departmental reviews. Each programme area will be evaluated during the programming cycle.

Cooperation with other organizations

59. The country programme of cooperation was the subject of consultation with partners within the United Nations system and with others, including NGOs. UNICEF will supplement UNDP support in the ongoing women-in-development programme. WHO will continue to provide technical inputs in the health sector, and the United Nations Educational, Scientific and Cultural Organization (UNESCO) will support the "Education For All" initiative. UNFPA will cofund the safe motherhood project. The proposed UNICEF programme will reinforce the efforts of USAID in the programme areas of health, nutrition and education.